



# **Good Practice Guidelines for Appraisal**

**Dr Laurence Mynors-Wallis**

**Dr David Fearnley**

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## 1. Introduction

This good practice guideline sets out advice for psychiatrists undertaking appraisal. It establishes the ground rules for a fair, useful and robust appraisal process. The guidance should be read with the other key documents that support revalidation: Revalidation Guidance for Psychiatrists, Good Psychiatric Practice (3rd edition) and Good Psychiatric Practice CPD. These documents are available on the Royal College of Psychiatrists website [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

Appraisal can be defined as “a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his or her work and to consider how his or her effectiveness might be improved” (DH, 2002). The process has been revised since its introduction for GPs and consultants in 2001 in part because of a number of high-profile inquiries about doctors’ poor performance and the variation in the quality of appraisal across the UK. Changes have been developed following a series of detailed reviews including: Good doctors, Safer Patients (2006), Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (2007), Medical Revalidation – Principles and Next Steps (2008), and Assuring the Quality of Medical Appraisal for Revalidation (2009).

Appraisal at its best should incorporate elements of assessment, performance management and personal development. To be effective, robust and meaningful, clinical governance systems should be in place to identify good and poor performance at individual and/or team level.

The NHS Revalidation Support Team has clarified the following aims for appraisal. Appraisal should be:-

- a. **Fair:** appraisal should be conducted fairly and consistently by competent and appropriately trained appraisers. It should be based on valid information and assessed against defined standards.
- b. **Supportive and developmental for doctors:** for the overwhelming majority of doctors who provide safe, effective and patient-centred care, appraisal should support practice, develop skills, encourage doctors and improve the quality of professional practice.
- c. **Protective of patient safety:** appraisal should act as a safety net, identifying practice where development and change is needed. This should happen only in rare circumstances where clinical governance has failed to identify and address such practice.
- d. **Streamlined:** Appraisal systems should seek to minimise the time taken to prepare portfolios, complete documentation and participate in the appraisal.
- e. **Practicable:** NHS medical appraisal should support, not disrupt, the delivery of care to patients. Its implementation should take account of the pressures of the service, integrating with clinical governance and the complexity of the modern healthcare environment.
- f. **Valid and evidence based:** The ability of strengthened appraisal to meet the criteria set out above needs to be piloted and evaluated.

This guidance applies to all psychiatrists both within and outside the NHS and across the United Kingdom. The guidance has been developed in consultation with revalidation and appraisal leads from across the UK, following a national conference in December 2009.

## **2. Link between appraisal and revalidation**

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise and that they are complying with the relevant professional standards. The Royal College of Psychiatrists has set out how psychiatrists demonstrate that they meet the standards of Good Medical Practice (for relicensing) and Good Psychiatric Practice (for recertification).

It will be through the appraisal process that psychiatrists will demonstrate that they are meeting the relevant standards. Satisfactory appraisals over a five year period will enable a Responsible Officer to recommend revalidation to the GMC.

The distinction is often made between summative and formative processes in appraisal. The summative component involves an assessment of what has happened whilst the formative part of appraisal involves identifying developmental needs and looking forward. A good appraisal involves both summative and formative components. The summative assessment of what has been achieved and what standards have been reached is necessary to inform the formative and developmental stage of the appraisal process.

## **3. Preparation for the appraisal meeting**

Preparation for appraisal should be part of a consultant's Supporting Professional Activity (SPA) or equivalent for doctors not employed in the NHS. It is envisaged that between 2-4 hours a month is sufficient to prepare for appraisal.

### **a. Supporting Information**

The appraisee is required to gather supporting information, referring to the standards in Good Medical Practice and Good Psychiatric Practice. The information collected will be from a number of areas of a doctor's practice and include evidence of meeting clinical standards, for example audits, outcomes and case based discussion, evidence of participating in Continuing Professional Development, feedback from colleagues and patients and evidence of reflection on care provided.

The General Medical Council has grouped the standards of Good Medical Practice into four domains, each with three attributes. The standards of Good Psychiatric Practice can also be considered in these twelve headings. The four domains and twelve attributes are:-

### ***Domain 1 Knowledge, skills and performance:***

- Attribute 1 Maintain your professional performance
- Attribute 2 Apply knowledge and experience to practice
- Attribute 3 Keep clear, accurate and legible records

**Domain 2 Safety and quality:**

- Attribute 4 Put into effect systems to protect patients and improve care
- Attribute 5 Respond to risks to safety
- Attribute 6 protect patients and colleagues from any risk posed by your health

**Domain 3 Communication, partnership and teamwork:**

- Attribute 7 Communicate effectively
- Attribute 8 Work constructively with colleagues and delegate effectively
- Attribute 9 Establish and maintain partnerships with patients

**Domain 4 Maintaining trust:**

- Attribute 10 Show respect to patients
- Attribute 11 Treat patients and colleagues fairly and without discrimination
- Attribute 12 Act with honesty and integrity

The appraisee is expected to consider which out of the twelve attributes they wish to present *supporting information* for in the appraisal for each year. All twelve attributes are to be covered in a five-year appraisal cycle for revalidation. The choice may arise from the previous year's Personal Development Plan (*PDP*) which will have areas of development agreed and which will link to at least one of the attributes. Some information will be presented each year, other information may only be required once in a five year cycle.

The appraisee should collect information that relates to all their professional roles. For appraisees in managed care organisations this will include information related to their employment and professional roles both within and outside their employing organisation. Appraisal must cover the whole scope of the doctor's work including management, research and teaching, the provision of specialist advice in not only the employing organisation (if any) but also all other areas of medical practice.

The framework of supporting information for psychiatrists can be summarised as follows:-

	Type of Information	Minimum required in 5 years	Comment
1	Case based discussion	10	Minimum 2 per year
2	Review of and reflection on complaints and serious untoward incidents	All	-
3	Audit	Complete 2 audits of significant clinical areas of practice over a 5 year cycle. Undertake at least 1 audit of record keeping in each 5 year cycle	
4	Patient feedback survey and review	1	To be presented no later than year 3
5	Colleague feedback survey and review	1	To be presented no later than year 3
6	New PDP and review of previous year's PDP	5	Annually
7	Meeting College CPD requirements	5	Annually
8	Clinical governance and other information (including outcomes) produced by the organisation and doctor	5	Annually
9	Information supporting non-clinical work eg. teaching, research, management	5	Annually if part of role

## b. Choice of Appraiser

The choice of an appraiser is to some extent to be determined by local agreement. The following standards should be used to guide such agreements:-

- i. The appraiser must be appropriately trained in the standards for psychiatric appraisal.
- ii. Mechanisms must be in place to both support the appraiser and to quality assure the appraisal process.
- iii. The majority of appraisals in each 5 year cycle should be done by a psychiatrist. It is not essential that each appraisal should be done by a psychiatrist from the same sub-speciality but appraisals should be undertaken by a colleague with a good understanding of the work being undertaken by the appraisee.
- iv. Each appraisee should be appraised no more than four times in succession by the same appraiser, unless there are compelling indications that this would be beneficial, for example, the implementation of a complex and ongoing personal development plan.
- v. In order to ensure continuity appraisees should ensure that they do not frequently change their appraiser.
- vi. Appraisees should be involved in a choice about their appraiser. In circumstances where concerns are being raised about practice, agreement must be reached with the local medical manager or Responsible Officer. Local policies should provide guidance about what an appraisee should do if they are concerned about the choice of appraiser.

## c. Pre-meeting

The appraisee and appraiser should make contact before the meeting to discuss the agenda and raise any particular points e.g. the first appraisal for a new consultant or specialty doctor, any significant gaps etc. The appraiser should formally invite the appraisee to the meeting, usually allowing about 2 hours for the meeting itself. The portfolio of supporting information should be delivered to the appraiser at least two weeks before the appraisal meeting.

If any third party is to be present, e.g. a patient or another appraiser as an external validator, this must be agreed with the appraisee before the meeting.

Areas that may require further thought before the appraisal meeting include: teaching activity (possible outside the main organisation), research, management and private practice. The appraisee may be asked to consider obtaining third party views as part of the supportive evidence e.g. feedback from trainees, academic head of department, line manager, operational director, Chief Executive etc.

The appraiser should check all supporting information provided to help avoid unnecessary distraction in the appraisal interview itself.

The appraiser should come to an opinion early on about whether there is sufficient supporting information to enable the appraisal interview to go ahead as planned, whether it should be adjourned, or whether a request for further information prior to the interview itself is necessary.

#### **4. The appraisal meeting**

##### **a. Practicalities**

Appraisal meetings are normally about 2 hours but this will vary depending upon the individual's circumstances.

Consideration needs to be given to the location of the appraisal meeting, convenient for both appraisee and appraiser but quiet and comfortable. A table should be available for the portfolio and other documents, and seating should allow ease of reference and note taking. Access to a computer is not normally required although the growing use of electronic portfolios make this a worthwhile consideration.

Appraisal meetings do not have to follow a rigid format, but generally the agenda should cover the following areas:

- Introductions and clarification of the appraisal process, progress so far and any particular issues to be considered. The appraisee should lead the discussion, systematically covering the portfolio and considering each domain and attribute. Whilst appraisal is both summative and formative, the move from summative towards formative discussion would be a logical sequence.
- The appraisee should discuss the PDP from the previous year. Attention to the success or otherwise of meeting the objectives in that PDP should be noted early on. Some may remain relevant objectives for the next year. Failure to achieve objectives should not automatically be seen as a concern, unless a very clear lack of regard or effort suggests otherwise. This should then be made very clear by the appraiser at the meeting e.g. "I see you have not met your objective to undertake...My view, from what you have told me is that this represents a lower standard than acceptable and therefore this must be met in the subsequent year, or the RO will become involved."
- Career advice and support are key aspects to the formative side of the appraisal process. It would be a natural part of the discussion to consider not only the next year but career aspirations beyond that. Doctors in career grade posts in particular may benefit from an opportunity to discuss this in the appraisal meeting.
- The GMP standard for note keeping are pertinent to the appraisal discussion. The record will be kept on the individual's personal file and is potentially disclosable to the RO and others. Decisions about revalidation may be based on these records and they are therefore very important.



b. Others at appraisal meeting

The majority of appraisals will consist of meeting with two doctors, the appraisee and the appraiser. It may be helpful to consider bringing in a third party into one or more of the appraisal discussions over a 5 year period, for example:-

- a. A lay person to provide a patient or carer perspective on the appraisal discussion.
- b. A sub-specialty colleague for individuals who practise in a very specialised area.
- c. A representative from a different organisation for doctors that work in two or more settings.
- d. A trained appraiser to quality assure the appraiser.

Clinical academic psychiatrists will be expected to have a joint appraisal involving both a clinical and university representative. In all cases there is a lead appraiser – typically a senior clinical academic for university employed psychiatrists.

c. Concerns

It is not possible to set out in rigid guidelines all the areas which might give rise to concern in appraisal.

The appraiser makes a judgement in each appraisal as to whether any concerns or issues that have come up in the appraisal are appropriately managed through the setting of objectives, as part of a personal development plan. This is the most likely outcome for most issues that arise in appraisal. The setting of such objectives is not an indicator of a poorly performing doctor but rather an understanding that there are areas in which training and practice can be strengthened.

If the appraiser identifies concerns that are not to be satisfactorily managed through agreement of a personal development plan, there are the following options:-

- a. To adjourn the appraisal to reflect and seek advice from colleagues as to an appropriate way forward before setting another date with the appraisee.
- b. If necessary to raise issues through organisational clinical governance structures.
- c. If there are immediate concerns about fitness to practise, these should be raised with the General Medical Council.

Examples which would raise concerns about ongoing practice would include the following:-

- i. Concerns about multidisciplinary working that is having an adverse impact on patient care and not responding to appropriate remediation.
- ii. Repeated failure to appropriately reflect and learn from adverse incidents and complaints.
- iii. Ongoing audits which continue to show poor standards of care attributable to the individual doctor's practice.

Known concerns should usually be handled outside the appraisal process providing the opportunity for the doctor to demonstrate appropriate action to address the issues.

d. Outcome of meeting

A crucial aspect of appraisal is the judgement of the appraiser with regard to the quality of supporting information and performance. This is illustrated below:

***A matrix of relationship between quality of supporting information and associated judgement of performance***

	Good performance	Poor performance
Good quality supporting information	a. Satisfactory appraisal	b. Satisfactory appraisal but performance concerns. Further actions needed e.g. PDP, Medical Manager, Responsible Officer, NCAS, GMC
Poor quality supporting information	c. Unsatisfactory appraisal. Adjourn within 3 months with clear agreement about what information is required	d. Unsatisfactory appraisal. Adjourn and consult Medical Manager, Responsible Officer, NCAS, GMC.

The table above aims to help guide the appraiser when facing one of four scenarios following an appraisal meeting.

- a. **Satisfactory appraisal.** This is the judgement that is made when good supporting information is presented and no concerns are raised throughout the appraisal meeting. This is likely to be the majority of psychiatrists.
- b. **Satisfactory appraisal process but significant performance issues.** This is when the psychiatrist has provided good supporting information but the information reveals concerns. The PDP must reflect this and have clear e.g SMART (Specific, Measurable, Achievable, Relevant, Timed) objectives that set out how and when the performance will improve. The

appraiser may refer to the Medical Manager, Responsible Officer, the National Clinical Assessment Service (NCAS) and also the GMC. Organisations should have clear local procedures in place for when difficulties arise.

- c. **Unsatisfactory appraisal – poor quality information.** The psychiatrist has not provided enough supporting information to satisfy the appraiser that GMP and GPP standards have been met. There may be no performance concerns but the appraisal is adjourned for no longer than 3 months, to ensure that the required information is provided.
- d. **Unsatisfactory appraisal and significant performance issues.** The psychiatrist has not provided sufficient supporting information and there are concerns about performance. The appraisal is adjourned and the Medical Manager, Responsible Officer, NCAS or GMC may be notified. The appraiser may need to seek advice before rescheduling a further appointment. Organisations should have clear local procedures in place for when difficulties arise.

The appraisal meeting will end with four statements agreed:

- i. Presence or absence of immediate concerns about the doctor's fitness to practise. If concerns exist the statement will specify in which attribute(s) concern exists
- ii. Whether there is sufficient supporting information recorded to demonstrate the doctor is making satisfactory progress towards revalidation
- iii. Whether there has been satisfactory progress with key elements in the previous year's Personal Development Plan
- iv. Agreement with the Personal Development Plan that derives from the current year's appraisal discussion to demonstrate the doctor is making satisfactory progress towards revalidation and that key priorities for development have been included in the plan

If these cannot be agreed, the appraisal is unsatisfactory and the process suggested in c and d above should be followed.

#### e. Content of a Professional Development Plan

A Personal Development Plan (PDP) is the tool used to assist the appraisee in improving practice. The items in such a plan may include specific, educational or learning tasks, for example visiting another unit to learn from best practice, specific tasks linked to areas of potential concern, for example undertaking an audit in an area of clinical practice or agreement as to which aspects of appraisal need to be completed before the next appraisal cycle, for example obtaining formal feedback from users and carers.

The content of a Personal Development Plan should be sufficiently challenging and ambitious to enable the doctor to improve practice but manageable within the context of the doctor's competing professional pressures.

## **5. After the appraisal meeting**

After the meeting the actions will relate to whether the appraisal was satisfactory (a or b) or unsatisfactory (c or d). A satisfactory appraisal will need to be confirmed in writing by the appraiser to the appraisee, within two weeks of the appraisal meeting, with a summary of which attributes were satisfied and what actions were agreed in the PDP. The appraisee is responsible for keeping the appraisal portfolio and summary as part of revalidation evidence.

In cases of unsatisfactory appraisal there is a need to establish whether simply more time is required to allow the appraisee to collect supporting information (scenario c) or should this appraisal be put on hold to allow performance management. The appraiser will notify the RO and (if they exist) line manager of the appraisee, as well as the appraisee, as soon as reasonably practicable. The appraiser is not expected to performance manage the appraisee – referring to the line manager helps keep the two processes separate. A psychiatrist in scenario d is clearly in need of performance management and/or remediation and whilst appraisal should be completed in good time e.g. 3 months, it may run parallel to a performance investigation, either internal or external.

## **6. Training**

Appraisees will benefit from training about strengthened medical appraisal and revalidation. This will help them prepare for the appraisal and gain the greatest benefits.

It is essential that appraisers are trained to deliver appraisal according to these guidelines. The fairness and rigour of appraisal is fundamental to the success of the new regulatory framework. Training involves both time on courses but importantly time as a reflective appraiser. A training programme should include the following areas:

- Experiences of appraisal
- Good Medical Practice and Good Psychiatric Practice
- Roles and responsibilities in the appraisal process. Appraisers need a clear understanding of how organisations which employ or contract with their appraisee works. In particular they should thoroughly understand its clinical governance arrangements, how quality of care is monitored, the clinical management structures and processes which support or constrain the doctor in his or her work, and how performance concerns are managed. Appraisers need to understand how to distinguish between matters that lie within the doctor's control through targeted action or personal development agreed during appraisal, and those that may need support or action from the organisation or Responsible Officer.
- Judgement. Appraisers must learn to form a judgement about whether there are any immediate or emerging concerns as to safety in the doctor's practice, whether the doctor remains up to date, and whether at the current stage in the cycle the doctor is on track to revalidate. Appraisers must develop the experience to benchmark a portfolio and assess the

evidence within the context of the stage of the revalidation cycle and the circumstances of the appraisee.

- Poorly performing doctors and performance management. Appraisers need to rehearse the situations in which it might come necessary to stop an appraisal discussion and instate occupational health or performance procedures because it has become clear that there is a patient safety issue.
- Communication skills. The communication skills to facilitate reflective practice and manage the in depth analysis of quality of care required for an appraisal must be assessed and developed during appraisal training. The appraisal discussion must facilitate personal and professional development and ensure that the doctor is aware whether or not they are on track for revalidation, and if not, help them to consider what steps should be taken to enable them to revalidate. High level communication skills will be required of all appraisers to enable them to support and challenge appropriately.

The Revalidation Support Team have identified five objectives for appraisers with supporting competencies (Department of Health, 2010). These objectives are given in Appendix 1.

A probationary period of twelve months is suggested as a reasonable means to ensure appraisers are competent and committed to the role. During this period, feedback should be obtained from appraisees and if practicable directly observed appraisal should occur.

## **7. Support for Appraisers**

Training will need to be supplemented and supported by participating in appraisal and having a peer group of appraisers to maintain and raise standards and discuss concerns.

Support for appraisers should include:-

- Access to leadership and advice on all aspects of the appraisal process from a named individual (eg. Appraisal Lead).
- Annual review of performance in the role of appraiser (as above) including suggestions for inclusion in their PDP addressing their development needs.
- Access to training and professional development resources to develop appraiser skills.
- Provision of peer support and discussion of difficult area of appraisal and significant events in an anonymised and confidential environment.
- Some appraisers may need access to external peer support because of their role within the organisation (eg. the Medical Director or Appraisal Lead) and/or their relationship to the other appraisers.

## 8. Confidentiality

No patient identifiable data should be held in the appraisal records by either the appraisee or appraiser. If potentially identifiable information is used eg. a complaint, it must be anonymised.

Whilst revalidation is a public demonstration of a doctor's continuing fitness to practise, the content of an appraisal discussion should remain confidential. In essence, the information informing appraisal, if not publicly available, should be available for scrutiny by those involved in quality assuring the appraisal process. Similarly the outcome of an appraisal, again whilst not being publicly available, should also be available for scrutiny by those who need to quality assure the appraisal process.

It is expected that there will be a gradual acceptance that the information supporting revalidation should more and more be available for public scrutiny to reassure both the public and the profession as to the quality of the appraisal process and the quality, fairness and transparency of the appraisal process.

Significant concerns about patient safety or issues that relate to fitness to practise cannot of course remain confidential.

## 9. Glossary

Appraisal - a process enabling doctors to have a formal and structured opportunity to reflect on their work and to consider how their effectiveness might be improved

Revalidation – the process by which doctors will have to demonstrate to the General Medical Council that they are up to date and fit to practise and that they are complying with the relevant professional standards. Revalidation will have two elements: relicensing and recertification

Relicensing – the process to show that all doctors are practising in accordance with the generic standards of practice set by the GMC and based upon the GMC's guidance *Good Medical Practice*

Recertification – the process to show that practising doctors who undertake specialist practice continue to meet the particular standards that apply to their medical specialty or area of practice. These specialty specific standards are set by the medical Royal Colleges and Faculties.

PDP – the documented set of objectives that arise from appraisal each year, and which form part of the personal development agreement between appraisee and appraiser which will inform successive appraisals and ultimately revalidation.

Responsible Officer – the exact duties are still being consulted upon but they are to ensure that the doctors for whom they are responsible have met the requirements for revalidation. In managed organisations this is likely to be the Medical Director.

Supporting information – the information that an appraisee presents to their appraiser. It tends to fall into four main areas: clinical activity, learning activity, review and reflection, and feedback from others.

## 10. References

Department of Health (2002) Appraisal for General Practitioners Working in the NHS. London: Department of Health. <http://www.dh.gov.uk/assetRoot/04/03/47/23/04034723.pdf>

GMC *Good Medical Practice* (2006)

[http://www.gmcuk.org/guidance/good\\_medical\\_practice/index.asp](http://www.gmcuk.org/guidance/good_medical_practice/index.asp)

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Good Psychiatric Practice, RCPsych, 3<sup>rd</sup> Edition (Feb 2009)

Revalidation Guidance for Psychiatrists, RCPsych (Oct 2009)

Strengthening NHS Medical Appraisal to Support revalidation in England, Revalidation Support Team (Nov 2009)

Strengthened Training of Appraisers for Revalidation – Draft. Revalidation Support Team (January 2010).

## **Objectives for Appraisers**

### **Objective 1 – Professional Responsibility**

Medical appraisers should demonstrate the highest standards of professional responsibility in all roles they undertake, clinical and non-clinical. They will normally be licensed clinicians registered with the GMC. Appraisers should be able to demonstrate commitment to medical revalidation by having undergone regular appraisal, and being engaged in the development in all domains of *Good Medical Practice* (GMC, 2004), so the appraiser is a good “role model” for medical appraisal and revalidation.

Appraisers should demonstrate that they take into account relevant general legislation and guidance on dealing with other people, such as, but not restricted to, equality and diversity, bullying and harassment, and data protection and confidentiality. They should show awareness of their own internal values and be able to make appropriate allowance for others of differing personal or medical backgrounds.

### **Objective 2 – Knowledge and Understanding**

Appraisers should be familiar with the purposes of medical appraisal and revalidation, nationally and for the organisation which employs them or contracts with them. They must understand the role of appraisal in improving the quality of medical practice and in supporting revalidation in the context of medical regulation.

Appraisers should understand the local and national appraisal and revalidation systems, policies and procedures, and how to apply them in practice.

Appraisers should be fully aware of their roles and responsibilities as an appraiser, in both what they should and should not undertake.

Appraisers should know the incentives and constraints related to local and national priorities for healthcare, particularly as they influence the care the appraisee is able to provide.

Appraisers should be able to understand the context within which an individual appraisee is working.

Appraisers should understand and promote the principles of adult education to help motivate, encourage and when appropriate empower their appraisees to achieve improvement through personal development. This includes the ability to make appropriate decisions, and/or facilitate and encourage the appraisee to make them.

### **Objective 3 – Assessment and Judgement in Appraisal**

Appraisers should be able to make appropriate recommendations to the Responsible Officer, following assessment of the supporting information provided by the appraisee, as to whether or not there are any immediate or emerging concerns about the doctor’s fitness to practise, whether the doctor is making satisfactory progress towards revalidation, whether there is satisfactory fulfilment of the previous years’ Personal Development Plans (PDPs), and whether there is agreement on the



PDP that derives from the current year's appraisal discussion.

These judgements must be drawn, as far as is possible, from objective assessment of verifiable supporting information including feedback from patients and colleagues.

#### **Objective 4 – Conduct of an Effective Appraisal**

Appraisers should demonstrate their ability to manage their own time and workload as an appraiser, including preparing adequately for every appraisal and completing all paperwork in a timely fashion.

Appraisers should demonstrate their ability to support the appraisee in the pre-appraisal preparation, and to set the context and gain agreement for the scope of the appraisal discussion.

Appraisers should demonstrate skills in the areas of agenda setting, prioritising, time keeping and managing the appraisal discussion.

Appraisers should demonstrate their ability to facilitate a well-structured and focused appraisal discussion that is centred on the appraisee's needs. They should encourage reflection on personal and professional development needs and the development of an appropriate portfolio of supporting information. The appraiser should use active listening, questioning and constructive challenge appropriately, and provide feedback to the appraisee. It is vital that the appraiser has good communication skills.

The appraiser should be alert for early warning signs of emerging performance, conduct or health concerns and know how to respond appropriately. Appraisers should be able to manage difficult situations and poor cooperation by an appraisee.

#### **Objective 5 – Documentation and Reporting**

Appraisers should be able to communicate effectively both verbally and in writing.

Appraisers should produce a high quality set of summary returns that accurately reflect the content of the appraisal discussion, identify agreed action points, record progress made and highlight examples of good performance.

Appraisers should be able to use the available tools, toolkits, other e-platforms and any requisite paper documents in support of the appraisal process effectively. They should be able to support the appraisee in their use of such tools during the appraisal discussion.